



**MASSACHUSETTS COMMISSION FOR THE BLIND'S
GIVE (GETTING INVOLVED IN VOLUNTEER EXPERIENCES) PROGRAM
VOLUNTEER APPLICATION**

NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ ZIP: _____

HOME TELEPHONE: _____ CELL PHONE: _____

E-MAIL _____

WHAT IS THE BEST WAY TO CONTACT YOU? (EMAIL, CELL, ETC) _____

DO YOU HAVE ANY VOLUNTEER EXPERIENCE OR SPECIAL TRAINING?

INTERESTS, HOBBIES, SKILLS AND LANGUAGES:

DO YOU HAVE PHYSICAL LIMITATIONS OR SPECIAL CONSIDERATIONS (ALLERGIES, ETC.)?

DO YOU SMOKE: YES _____ NO _____

DO YOU MIND OTHERS SMOKING: YES _____ NO _____

HOW WOULD YOU LIKE TO VOLUNTEER: (PLEASE CHECK ALL THAT APPLY)

READING	DRIVING	SHOPPING	FRIENDLY VISITOR	RECREATION
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TIME(S) AVAILABLE: (PLEASE CHECK ALL THAT APPLY)

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
MORNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AFTERNOON	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EVENING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THE FOLLOWING IS REQUESTED ONLY FOR VOLUNTEERS PROVIDING TRANSPORTATION;

THESE VOLUNTEERS MUST HOLD A VALID DRIVER'S LICENSE:

DRIVER'S LICENSE NUMBER: _____ EXPIRATION DATE: _____

NAME OF INSURANCE COMPANY:

LIST ANY ACCIDENTS AND/OR MOVING VIOLATIONS IN THE PAST 3 YEARS (EXCLUDING PARKING

TICKETS): _____

WHAT YOU BELIEVE TO BE YOUR STRENGTHS FOR VOLUNTEERING:

PLEASE LIST TWO (2) REFERENCES AND YOUR CURRENT EMPLOYER, IF APPLICABLE:

<u>NAME</u>	<u>EMAIL/PHONE</u>	<u>HOW DO YOU KNOW THIS PERSON?</u>
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1.	<hr/>	
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2.	<hr/>	
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3.	<hr/>	
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CITIES AND TOWNS WHERE YOU WOULD LIKE TO VOLUNTEER:

HOW DID YOU HEAR ABOUT US?

AGREEMENT AND SIGNATURE:

I HEREBY CERTIFY THAT THE FACTS SET FORTH IN THE ABOVE VOLUNTEER APPLICATION ARE TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IF I AM ACCEPTED FOR MCB'S VOLUNTEER PROGRAM, I MAY BE SUBJECT TO DISMISSAL IF I HAVE FALSIFIED STATEMENTS ON THIS APPLICATION. I UNDERSTAND AND AUTHORIZE THE COMMONWEALTH TO PERFORM A CRIMINAL OFFENDER RECORD INFORMATION (CORI) CHECK.

PRINT NAME:

SIGNATURE:

 DATE:

PLEASE RETURN COMPLETED FORM TO:

MASSACHUSETTS COMMISSION FOR THE BLIND
600 WASHINGTON STREET
BOSTON, MA 02111
ATTN: LAURIE KORAJCZYK
617-626-7575 800-392-6450 x626-7575
MCBVOLUNTEER@STATE.MA.US